Testimony

of

David Satcher, M.D., Ph.D.
Surgeon General and Assistant Secretary for Health

U.S. Department of Health and Human Services

before the

Commerce, Science and Transportation Committee
United States Senate

October 5, 2000

Good morning, Mr. Chairman and members of the Commerce Committee. I am Dr. David Satcher,

Surgeon General and Assistant Secretary of Health for the U.S. Department of Health and Human Services. I am pleased to appear before you and present testimony on our newest tobacco-related Surgeon General=s Report, *Reducing Tobacco Use*. I am accompanied by Dr. Terry Pechacek, Associate Director for Science in the Office on Smoking and Health at the Centers for Disease Control and Prevention (CDC).

Mr. Chairman, I want to express my appreciation, particularly at what I know is a very busy time in the legislative session, for your holding this hearing and for the concern and leadership in tobacco control issues that you and this Committee have shown.

This is the 29th report on tobacco issued by the Surgeon General. It is the first-ever to provide an in-depth analysis of the various methods to reduce tobacco use. Our report shows that we have the tools, the knowledge and the resources to cut smoking rates in half by the end of the decade. The question is: Do we have the will?

In my testimony, I will refer to three important documents that contain information that can be used to shape the future of tobacco control. First is the Surgeon General=s report I just mentioned. This report provides a blueprint for achieving the ambitious health objectives for the nation, which are laid out in Healthy People 2010Bthe second important document, which contains 17 tobacco-related objectives. Finally, CDC has made this information more concrete with the *Best Practices for Comprehensive Tobacco Control Programs*, which was prepared to help states assess options for comprehensive tobacco control programs and to evaluate their local funding priorities. If you don=t already have copies of these important documents, all three are available on-line and I have a few copies with me today.

Overview

As I am sure you are aware, the need to address the public health consequences of tobacco use is urgent. Tobacco use is responsible for more than 430,000 deaths each year, or one in every five deaths. It is the single most preventable cause of death and disease in our nation, and it is well

documented that smoking can cause chronic lung disease, coronary heart disease, and stroke, as well as cancer of the lung, larynx, esophagus, mouth, and bladder. Smokeless tobacco and cigars also have deadly consequences including cancer of the lung, esophagus, and mouth. In addition to this enormous health burden, the economic burden of tobacco use is more than $50 billion in medical expenditures and another $50 billion in indirect costs annually. The harmful effects of smoking do not end with the smoker—environmental tobacco smoke causes an estimated 3,000 deaths from lung cancer each year, and causes up to 300,000 episodes of lower respiratory tract infections in children each year.

Surveillance data reported in today=s issue of CDC=s *Morbidity and Mortality Weekly Report* indicate that the prevalence of cigarette use among adults has changed very little during the 1990s—about one-quarter of adults reporting current cigarette use. Among adolescents, smoking prevalence rates steadily increased from 1991-1997, but preliminary new data show that the rates have peaked and are starting to decline. However, if tobacco-use patterns do not decline more rapidly than current trends indicate, an estimated five million persons who were less than 18 years of age in 1995 will die prematurely from a smoking related disease.

Reducing Tobacco Use: A Report of the Surgeon General

The good news related to tobacco is that although our knowledge of tobacco control remains imperfect, we know more than enough to act now. The Surgeon General=s Report on *Reducing Tobacco Use* is the first-ever report that provides an in-depth analysis of tobacco intervention strategies. This reports offers a science-based blueprint for achieving our Healthy People 2010 health objectives to cut adult and teen smoking rates in half. One of the key conclusions of our Surgeon General=s report is that existing state tobacco control programs have provided evidence of the efficacy of a comprehensive approach to reducing tobacco use.

This type of comprehensive approach--one that combines educational, clinical, regulatory, economic, and social strategies--has emerged as the guiding principle for future efforts to reduce tobacco use.

Evidence shows that multifaceted state tobacco control programs are effective in reducing tobacco use in part because they bring about a shift in social norms and reduce the broad cultural acceptability of tobacco use. Comprehensive approaches combine community interventions, counter-marketing, and program policy and regulation.

The goal of a comprehensive tobacco control program is to reduce disease, disability, and death related to tobacco use by: (1) promoting quitting among adult and youth smokers; (2) preventing young people from ever starting to smoke; (3) implementing public health policies to protect citizens from secondhand smoke; and (4) eliminating racial and ethnic disparities in tobacco-related diseases.

To assist states in achieving these goals, the CDC has prepared guidelines to help states determine funding priorities and to plan and carry out effective comprehensive tobacco prevention and control programs. In CDC=s *Best Practices for Comprehensive Tobacco Control Programs*, CDC recommends that states establish tobacco prevention and control programs that are ***comprehensive***, ***sustainable***, and ***accountable***.

The guidelines draw on best practices determined by evidence-based analyses of excise tax-funded programs in California, Massachusetts, Oregon and Maine and in the four states that individually settled lawsuits with tobacco companies (i.e., Florida, Minnesota, Mississippi, and Texas).

Evidence from California, Massachusetts, and Oregon--and more recent results from Arizona and Maine-- indicate that increasing the price of cigarettes reduces tobacco consumption rates. In addition, evaluations have shown that an adequately funded, comprehensive tobacco prevention and control program can result in even more dramatic reductions when coupled with price increases. Data from California provide the best example of this. The state excise tax was increased from $0.10 to $0.35 in January 1989 to fund the new tobacco control program. There was an initial and rapid reduction in consumption as a result of the January 1989 price increase. If price were the only factor in contributing

to the declines in California, we would expect the rates to drop initially and then follow the similar pattern of slow decline experienced by the rest of the country. However, as a result of the tobacco control program implemented in California, the rates of tobacco use in California continued to decline two to three times faster than in the rest of the country throughout the 1990s. Between 1988 and 1999, per capita cigarette use in California has declined by almost fifty percent while in the rest of the country, rates have declined by only about twenty percent.

CDC is conducting an in-depth analysis of state tobacco control programs for all 50 states. Evaluation data from the statewide comprehensive tobacco control programs indicate that there is a dose-response relationship between investment in tobacco prevention and control and reductions in tobacco use in the state.

"Best Practices" -- Program Components

CDC recommends that states establish tobacco control programs that contain the following nine elements:

- Community Programs to Reduce Tobacco Use
- Community Programs to Reduce the Burden of Tobacco-Related Diseases
- School Programs
- Enforcement
- Statewide Programs
- Counter-Marketing
- Cessation Programs
- Surveillance and Evaluation
- Administration and Management

The Surgeon General's report provides further discussion on the specific strategies that might be

adopted in each of these areas, and reviews the scientific literature about their efficacy, so I will limit my remarks to describing the programmatic components included in the CDC guidelines and briefly touch on the extent to which they are currently being implemented by states.

Community Programs to Reduce Tobacco Use

To achieve the individual behavior change that supports the non-use of tobacco requires whole communities to change the way tobacco is promoted, sold, and used while changing the knowledge, attitudes, and practices of young people, tobacco-users, and nonusers. Effective community programs involve people in their homes, work sites, schools, places of worship and entertainment, civic organizations, and other public places. To achieve lasting changes, programs in local governments, voluntary and civic organizations, and community-based organizations require funds to hire staff, provide operating expenses, purchase educational materials, provide education and training programs, support communication campaigns, organize the community to debate the issues, establish local plans of actions, and draw other leaders into tobacco control activities. While most states are supporting community programs, these programs are not yet reaching the entire state population. Evaluation reports from the states of California, Massachusetts, and Oregon indicate that very encouraging progress has been made by local communities in these states to protect nonsmokers from environmental tobacco smoke, limit youth access to tobacco products, and restrict local tobacco advertising.

Community Programs to Reduce the Burden of Tobacco-Related Diseases

Another element of community programs reflects the fact that tobacco use increases the risk of development of a number of diseases. Even if current tobacco use stopped, the residual burden of disease among past users would cause disease for decades in the future. Community programs can focus attention directly on these diseases, both to prevent them and detect them early. Comprehensive, state-based tobacco prevention and control programs can address diseases for which tobacco use is a major cause, such as cancer, cardiovascular disease, stroke, oral cancers, and asthma.

School Programs

The recent Surgeon General's Report, *Reducing Tobacco Use*, concluded that educational strategies, conducted in conjunction with community- and media-based activities, can postpone or prevent smoking onset in 20 to 40 percent of adolescents. Because most people who start smoking are younger than age 18, school-based programs that prevent the onset of smoking are a crucial part of a comprehensive tobacco prevention program. Several studies have shown that school-based tobacco prevention programs, which identify the social influences that promote tobacco use among youth and teach skills to resist such influences, can significantly reduce or delay adolescent smoking. Because many students begin using tobacco before high school and impressions about tobacco use are formed even earlier, tobacco use prevention education must be provided in elementary school and continued through middle and high school grades.

To address this need, CDC collaborates with more than 30 professional and voluntary organizations to assist schools and agencies in developing model policies and guidelines. States are using these to implement effective school health programs. However, less than 5 percent of schools nationwide are implementing the major components of CDC=s *School Health Guidelines to Prevent Tobacco Use and Addiction*. Of the states that are working to follow the guidelines, such as Maryland and Oregon, they struggle to reach all school age children. Furthermore, despite Oregon=s intensive efforts to implement the guidelines, they reach only 30 percent of the school districts.

Enforcement

The Surgeon General=s report concluded that enforcement of tobacco control policies enhances their efficacy both by deterring violations and by sending a message to the public that the community believes the policies are important. The primary areas addressed by local and state policies that require enforcement strategies are restrictions on minors= access to tobacco and restrictions on indoor smoking in public places. As other policy changes (e.g., local restrictions on advertising and promotion) are adopted, they also will need to be enforced. The state of Florida is implementing an enforcement

program consistent with CDC=s *Best Practices*.

Statewide Programs

Also consistent with the Surgeon General=s report, funding to support statewide programs is a major element of CDC's recommended comprehensive approach to the prevention and reduction of tobacco use. Statewide projects can increase the capacity of local programs by providing technical assistance on evaluating programs, promoting media advocacy, implementing of smokefree policies, and reducing minors' access to tobacco. Supporting organizations that have statewide access to diverse communities can help eliminate the disparities in tobacco use among the state's various racial and ethnic groups. Statewide and regional grants to organizations representing cities, business and professional groups, law enforcement, and youth groups inform and involve their membership about tobacco control issues and encourage their participation in local efforts. Arizona, California, Maine, Massachusetts and Oregon currently have statewide programs that serve as Abest practice@ models to reach diverse communities.

Counter-Marketing

One of the major conclusions of the Surgeon General=s report is that efforts to prevent the onset or continuance of tobacco use face the pervasive and countervailing influence of tobacco promotion by the tobacco industry. During the last decade, the industry has spent more than $20 billion in imagery advertising and promotions to create a Afriendly familiarity@ for tobacco products and an environment in which smoking is seen as glamorous, social, and normal. This is of particular concern since studies show that children buy the most heavily advertised brands and are three times more affected by advertising than adults.

To counter this influence, tobacco control programs should undertake counter-marketing activities that can promote smoking cessation and decrease the likelihood of initiation. In addition, counter-marketing messages can have a powerful influence on public support for tobacco control intervention and set a supportive climate for school and community efforts. Counter-marketing attempts to counter

pro-tobacco influences and increase pro-health messages and influences throughout a state, region, or community. Counter-marketing consists of a wide range of efforts, including paid television, radio, billboard, and print counter-advertising at the state and local level; media advocacy and other public relations techniques using such tactics as press releases and local events and pro-health promotional activities; and efforts to reduce or replace tobacco industry sponsorship and promotions.

Some states are initiating significant counter-marketing efforts. Multifaceted prevention programs, such as the Minnesota Heart Health Program and the University of Vermont School and Mass Media Project, have shown that comprehensive efforts that combine media, school-based, and community-based activities can postpone or prevent smoking in 20 percent to 40 percent of adolescents. Although the relative effectiveness of specific message concepts and strategies is widely debated, research from all available sources shows that counter-marketing must have sufficient reach, frequency, and duration to be successful. The Vermont youth campaign, for example, exposed 50 percent of the target population to each TV and radio spot about six times each year over a 4-year period. This level of exposure is possible only through paid media placement.

The Florida TRUTH campaign has achieved high levels of exposure among target aged youth that their evaluation reports suggest are related to the their impressive declines in rates of youth tobacco use. The award-winning Massachusetts counter-marketing campaign has focused on prevention of initiation, promotion of cessation, and protection of non-smokers and reports both high levels of exposure to its multiple message themes as well as direct impacts on adult attempts to quit and prevention of youth initiation rates.

Cessation Programs

You may be aware that the Public Health Service (PHS) has recently published evidence-based clinical practice guidelines on cessation. Tobacco dependence is a chronic condition that often requires repeated intervention. The PHS Guideline, "Treating Tobacco Use and Dependence," provides

recommendations which are both clinically effective and cost-effective relative to other medical and disease prevention interventions.

Cessation is a particularly important component of tobacco control programs, because programs that successfully assist young and adult smokers in quitting can produce a quicker and probably larger short-term public health benefit than any other component of a comprehensive tobacco control program. Smokers who quit smoking before age 50 cut in half their risk of dying in the next 15 years. In addition, the cost savings from reduced tobacco use resulting from the implementation of moderately-priced, effective smoking cessation interventions would more than pay for these interventions within 3 to 4 years. Unfortunately, no state currently has fully implemented the best practices recommendations in this area. However, the states of California, Oregon, Arizona and Massachusetts have developed innovative approaches to increase access to evidence-based treatments for nicotine addiction. We encourage other states to follow their lead.

Surveillance and Evaluation

The Surgeon General's report stressed the importance of expanding the science base in support of comprehensive tobacco control programs. Hence, a statewide programs must have a sound surveillance and evaluation system both to monitor fiscal accountability for state policy makers as well as to increase the efficiency and effectiveness of program activities. For this reason, the establishment of surveillance and evaluation systems must have first priority in the planning process. With technical assistance from CDC, California, Massachusetts, Oregon, Arizona, Maine, and Florida have established comprehensive surveillance and evaluation systems based upon CDC=s *Best Practices*= recommendations.

Administration and Management

An essential component of an effective tobacco control program is a strong management structure.

Experience California, Massachusetts and Oregon has shown the importance of having all of the program components coordinated and well-managed. A comprehensive program involves multiple state agencies (e.g., health, education, and law enforcement) and multiple levels of local government, as well as numerous health-related coalitions, voluntary and community groups. Coordination of these groups requires high quality program administration and management. Many states have difficulty maintaining a comprehensive tobacco control program and rely on federal support to maintain key management and administrative personnel.

Conclusion

Only three years ago, tobacco control spending in almost all states averaged pennies and nickels per capita. Now all states have a sound core funding, and current allocations in those states with expanded programs range from $2.50 to more than $10 per capita. While these funding sources and levels have contributed to the development of a basic capacity within states to conduct tobacco prevention and control programs, no state is currently implementing all the components recommended in CDC=s *Best Practices*. Approximate annual costs to implement all of the recommended program components have been estimated to range from $7 to $20 per capita in smaller states (population under 3 million), $6 to $17 per capita in medium-sized states (population 3 to 7 million) and $5 to $16 per capita in larger states (population over 7 million).

While the focus of today=s discussion is on state efforts to address tobacco use, a comprehensive national tobacco control effort requires strategies that go beyond state programs. A comprehensive national effort should involve the application of a mix of educational, clinical, regulatory, economic and social strategies. In each of these areas, some of the program and policy changes that are needed can be addressed most effectively at the national level. That is why the Administration has sought FDA authority to restrict advertising and sales of tobacco products to children, and taken actions such as establishing smoke-free workplaces to protect the health of federal employees and visitors to federal buildings. Even as we have encourage states to use their settlement funds to help support tobacco

prevention programs in states and local communities, we also have increased federal support for those programs.

Progress is being made, but a great deal remains to be done. States such as California, Massachusetts, Arizona, Oregon, Maine, and Florida are demonstrating that significant reductions in tobacco use rates among young people and adults are possible. However, our Healthy People 2010 objectives, including cutting in half the rates of tobacco use among young people and adults, will require a sustained and comprehensive effort at both the federal and state level. The Surgeon General report and CDC=s *Best Practices* provide the blueprint for what needs to be implemented. Prevalence of cigarette use among adults in this nation has changed very little during the 1990s. Each year, more than 1 million young people continue to become regular smokers and more than 400,000 adults die from tobacco-related diseases. We know what strategies are effective in controlling tobacco use. What we need now is a stronger, sustained effort by government at all levels to implement these proven tobacco control strategies. Tobacco use will remain the leading cause of preventable illness and death in this nation and a growing number of other countries until tobacco prevention and control efforts are commensurate with the harm caused by tobacco use. We look forward to working with you and our other partners, some of whom will be addressing you shortly, to address this urgent public health issue.